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# Automation in Transportation Accidents

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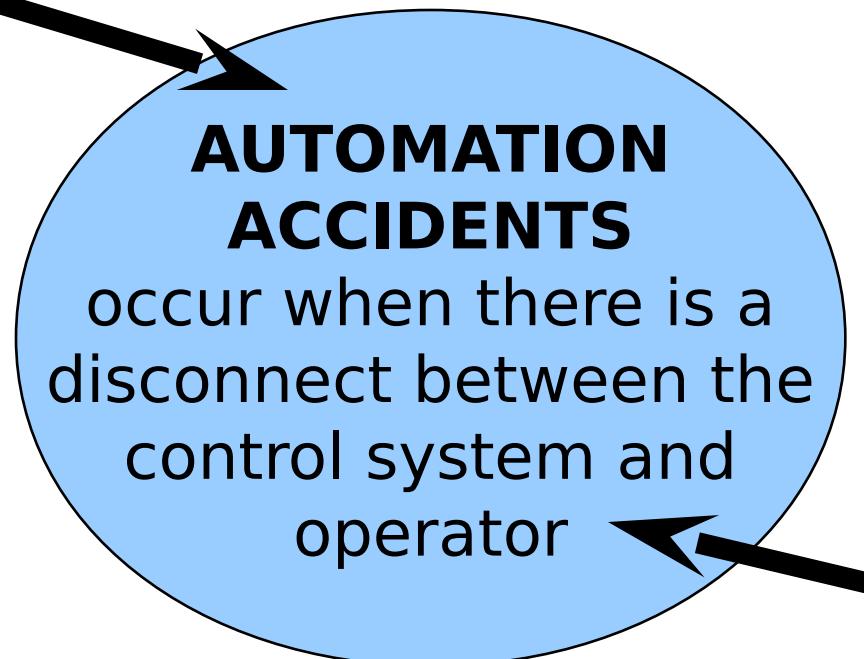
National Transportation Safety  
Board

Washington, DC



# Automation Accidents

**Control System Design**



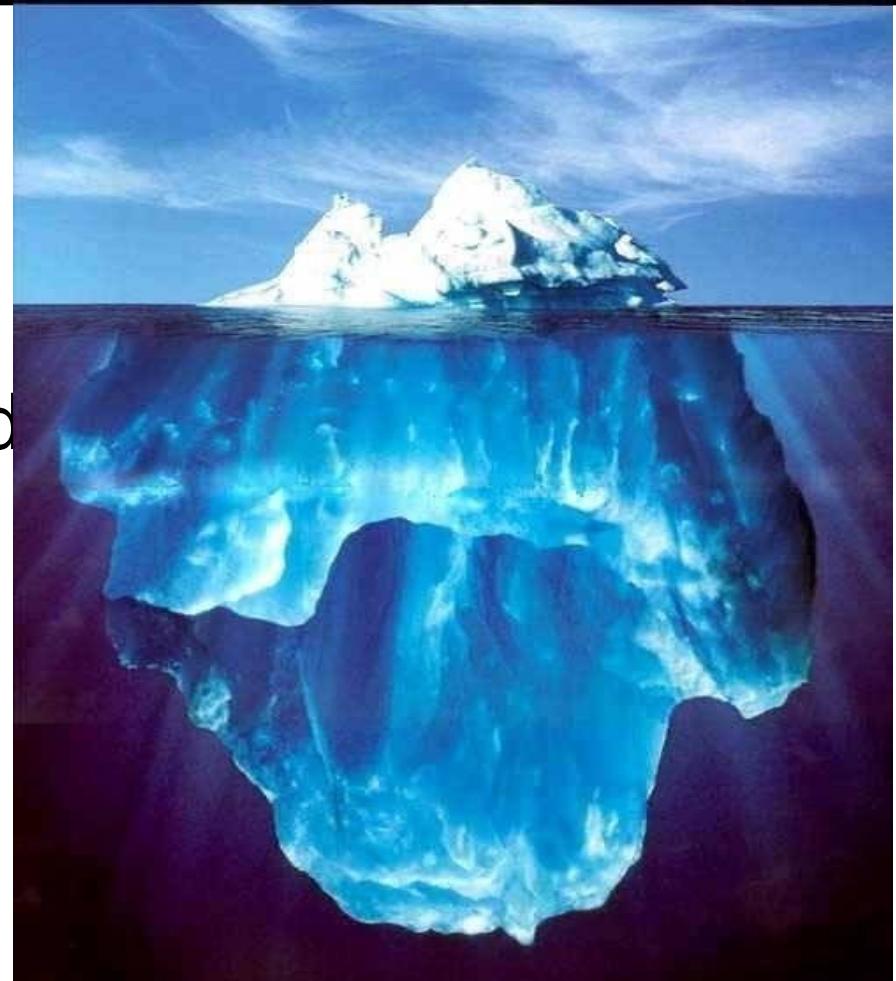
**Person**

- Monitoring
- Task overload
- Expectancy
- Inattention
- Complacency
- etc...



# The Role of Automation

- Transportation databases focus on fatalities
- Automation-related mistakes difficult to analyze
- Varied and inconsistent taxonomies





# Accident Examples

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- Washington Metro Train Collision
  - Shady Grove MD on Jan 6, 1996
- Grounding of the Royal Majesty
  - Near Nantucket on June 10, 1995
- Pipeline release of hazardous liquid
  - Near Gramercy LA on May 23, 1996
- A300 Inflight Upset
  - Near West Palm Beach FL on May 12, 1997



## System Map

### Legend

Red Line • Glenmont/Shady Grove  
Orange Line • New Carrollton/Braddock Rd/Fairfax-GMU  
Commuter Rail • MARC • MARC Commuter • MARC Station  
Green Line • Branch Avenue/Greenbelt  
Yellow Line • Huntington/Mt. Vernon Sq/7th St-Convention Center



# Metro train





# Pre-Accident Events

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- Severe snow storm track conditions worsening.
- All Metrorail trains were functioning in Automatic train operation as opposed to Manual operations.
- Computerized system at Metro's Operations Control Center controls train acceleration, speed, and braking.
- Train operator responsible primarily for monitoring train functions and ensuring safe operations.



# Metrorail Operations Control Center

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- Controllers monitor and direct operations throughout the system.
- Controllers set parameters for trains by assigning the train's "performance levels" (train's acceleration and top speed).
- Under new Metro policy, controllers were not permitted to authorize train operators to change from automatic to manual mode except in emergencies.



# Metro Operating Practices

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- High number of wheel flats on Metro train . . . because of braking slides in manual mode.
- The November 17, 1995, notice instructing controllers *not* to permit train operators to change to manual mode (except in emergencies).
- The Jan. 6, 1996 storm was the first serious snow storm after change - - first real test of the new policy.



# Accident Sequence

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- Controllers instructed the train to continue Automatic mode, set speed at lower performance level (59 mph).
- Train overruns Twinbrook Station (told by controllers not to service station go to next in Automatic mode).
- The train then overran Rockville Station by one car. Results in *performance level* loss because the train was not within platform limits.
- Thus, the train departed to Shady Grove Station at 75 mph (rather than 59 mph). Train overran station by 470 ft, struck and telescoped 21 feet into standing train.



# NTSB Findings

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- Safety Board found over reliance on system automation to ensure safe train operations.
- Controllers had responsibility for day-to-day train operations, but lacked authority.
- For the 20 year history of Metrorail, controllers routinely gave permission for train operators to change to manual operation during periods of inclement weather.
- Controllers felt that train operator could do a better job of controlling the trains manually in slippery track conditions.



# NTSB Conclusions

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- Metro management practices were inconsistent with complex automated rail system.
- Decisions for highly technical automated systems usually affect other activities (and sometimes produce unanticipated hazards).
- Metrorail management failed to fully understand the design features and limitations of the automatic train control system--
- Which led to unjustified management confidence that the system could ensure safe train operation under all operating conditions.



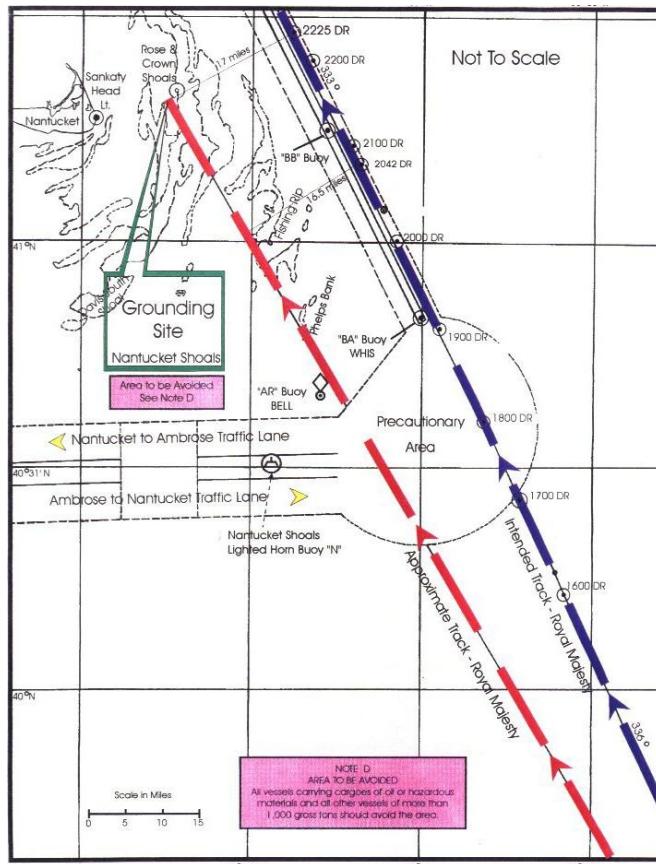
# Royal Majesty

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# Navigational Track





# Integrated Control Bridge

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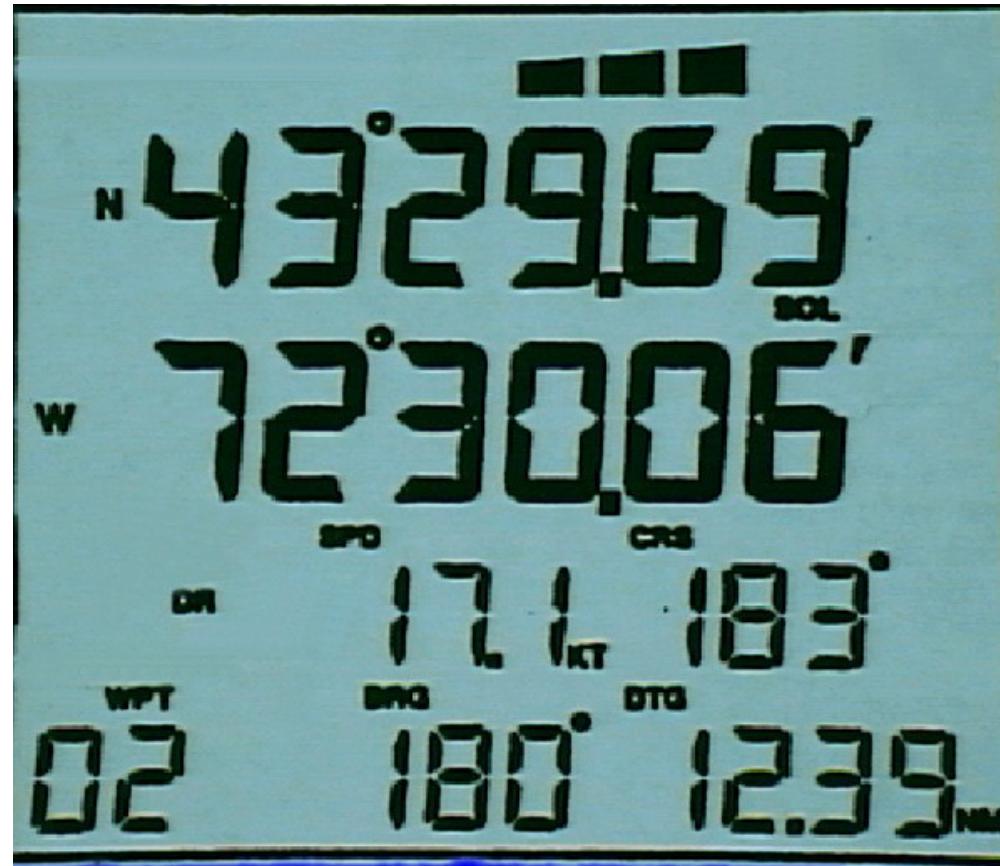


# Chartroom





# GPS Display





# Pipeline Control System

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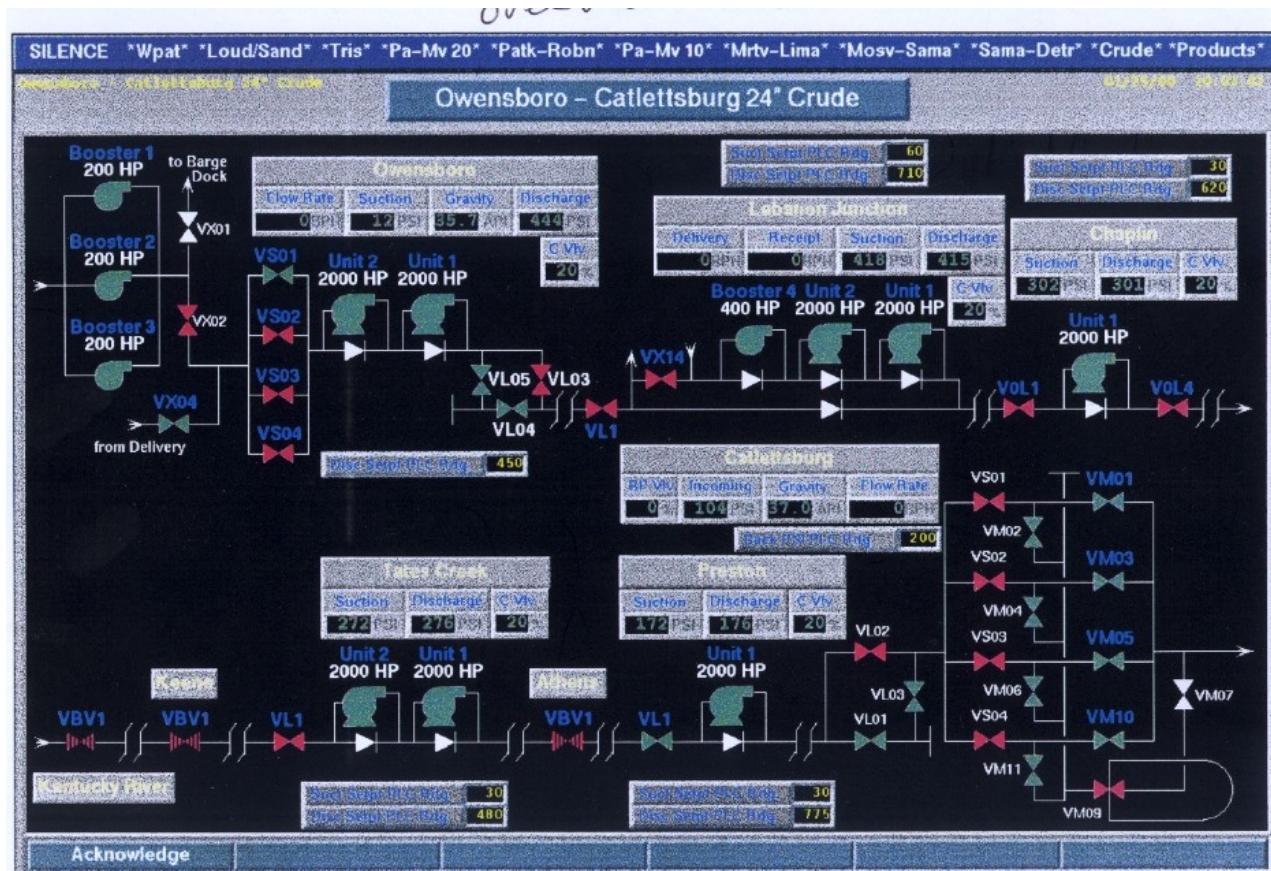


# SCADA System





# Process Control Screen







# A300-600 Inflight Upset

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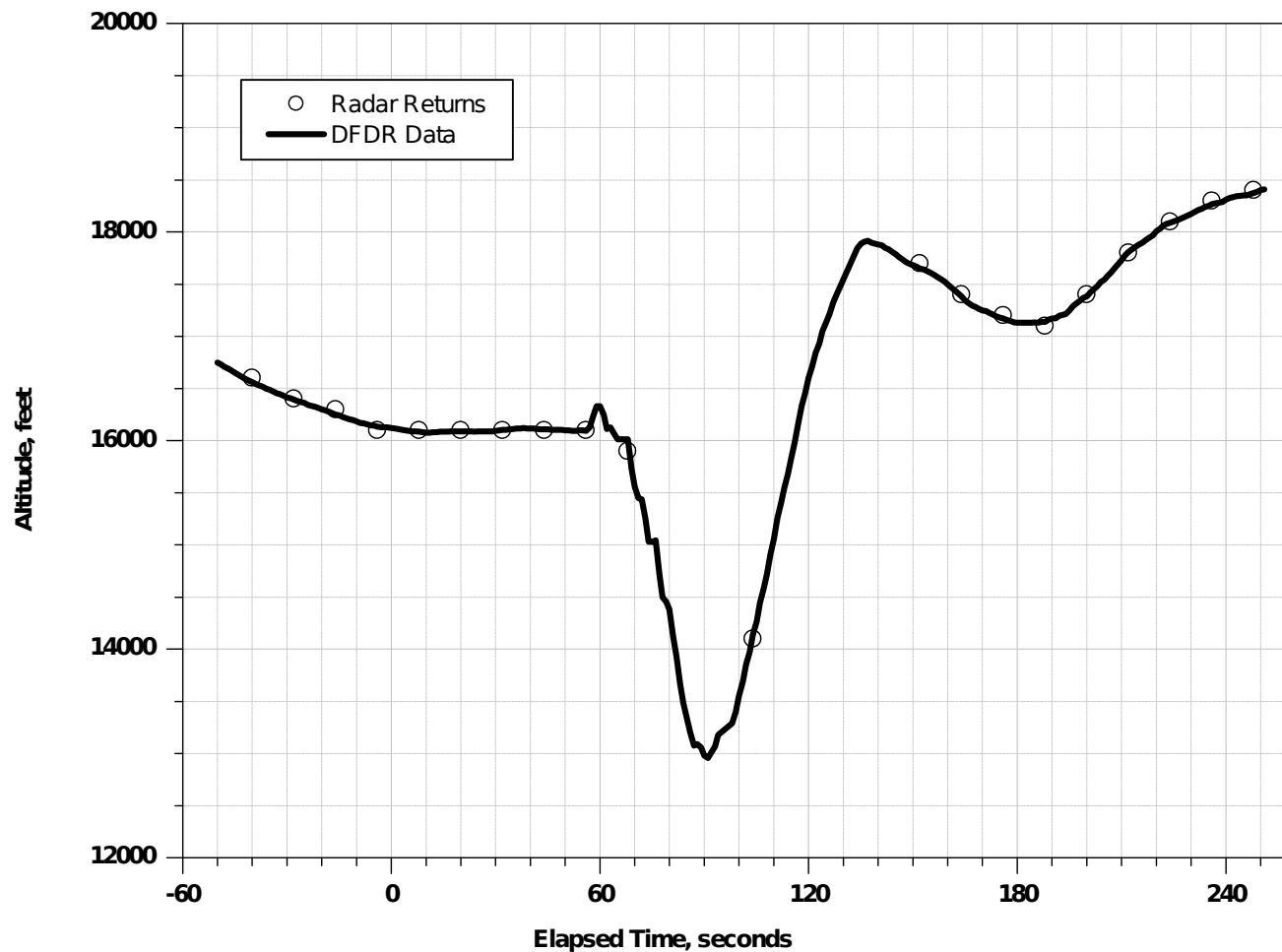
# Event Sequence

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- Autothrottle set to hold 210 knots
- Engaged at start of descent from FL240
  - During descent - power reduced from idle to mechanical stops
- Not engaged at level off at FL160
- Airspeed decreased
- About 170 knots flightcrew advanced throttles
- Stall warning activated and upset occurred
- No evidence of autothrottle malfunction



# AA 903 Altitude Plot





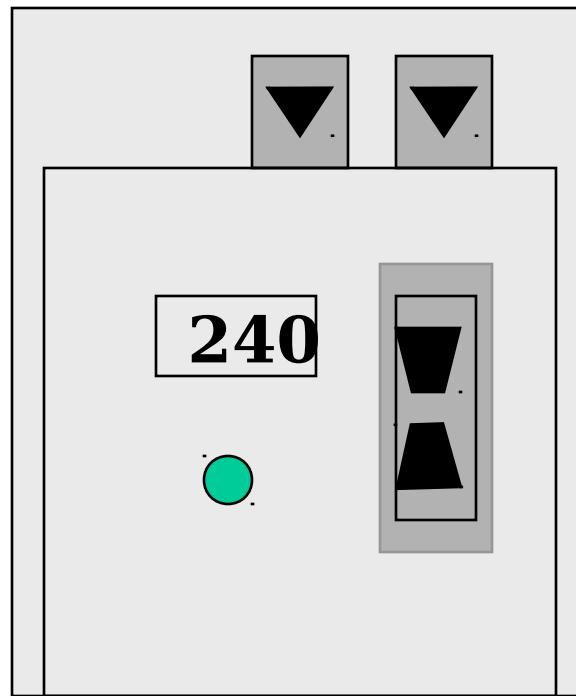
# Cockpit





# Instrument Diagram

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# Autothrottle Controls

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- Engaged via button on glareshield
- Disengage - depress disconnect button on throttle, FMA to amber “MAN THR”, green bars on FCU out
- Other airplanes have warning systems requiring additional flightcrew action
- A300 - passive and persistent indications
- More typical of information display, does not command attention, possible delay between inadvertent disconnect and recognition



# A300 Upset Loss of Displays

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- Primary flight controls went out momentarily during upset
- Replaced by indication that computers driving the displays were undergoing automatic reset and self-test
- Function designed to detect unreliable data - monitors flight parameters



# A300 Upset Loss of Displays

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- Reset threshold for roll rate - greater than 40 degrees per second
- Airbus first time reset reported during upset
- Recommendation issued to FAA asking that Airbus modify this software on A300 because of the potential for loss of information during unusual attitude recovery



# What do these accidents tell us?

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- Role of defaults in adaptive automation
- Effects of high false alarm rates
- Dangers of passive monitoring
- Unanticipated failure modes

*and, that training just won't cover everything*